SUPERVISORY CONTRACT

KENTUCKY BOARD OF LICENSED PROFESSIONAL COUNSELORS
PO BOX 1360
FRANKFORT KY 40601

TO BE COMPLETED BY INDIVIDUALS WHO HAVE ALL ACADEMIC REQUIREMENTS (MASTER'S DEGREE IN COUNSELING OR RELATED FIELD WITH A 60 SEMESTER HOURS OF COURSEWORK WITHIN THE REQUIRED 9 AREAS, INCLUDING A 400 HOUR PRACTICUM/INTERNSHIP).

## APPLICANT INFORMATION

FIRST NAME MIDDLE NAME LAST NAME

_____/_____/_____ (___)_____ (___)_____
SOCIAL SECURITY # HOME TELEPHONE # WORK TELEPHONE #

STREET ADDRESS

CITY STATE ZIP

## SUPERVISOR INFORMATION
## (COMPLETE A SEPARATE FORM FOR EACH SUPERVISOR)

FIRST NAME MIDDLE NAME LAST NAME

STREET ADDRESS

CITY STATE ZIP

(___)_____ _____ _____
TELEPHONE # TYPE & TITLE OF LICENSE HELD LICENSE #

_____/_____/_____ _____/_____/_____
DATE OF ISSUE (Please attach copy) EXPIRATION DATE (Please attach copy)

## INFORMATION RELATED TO SUPERVISED EXPERIENCE

NAME OF ORGANIZATION OR AGENCY WHERE EXPERIENCE WILL BE GAINED (COMPLETE A SEPARATE FORM FOR EACH SETTING):

STREET ADDRESS OF ORGANIZATION OR AGENCY

CITY STATE ZIP

AVERAGE NUMBER OF HOURS EXPECTED TO BE GAINED PER WEEK: _____

BEGINNING DATE OF SUPERVISED EXPERIENCE:_____
ESTIMATED ENDING DATE:_____

TYPE OF SETTING: GOVERNMENT AGENCY_____ HOSPITAL_____
NON-PROFIT_____ PRIVATE PRACTICE_____
SCHOOL_____ VOLUNTEER_____ OTHER_____

TYPE OF COUNSELING EXPERIENCE TO BE GAINED (CHECK ALL THAT APPLY)
ACADEMIC_____ CAREER & VOCATIONAL_____ CHILD & ADOLESCENT_____
DRUG & ALCOHOL_____ GENERAL_____ GROUP_____MARRIAGE &
FAMILY_____ REHABILITATION_____ OTHER_____

I, as applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules.

That I will meet with my supervisor approximately one hour each week with a minimum of three hours per month of documented supervised experience.

That I will abide by all rules of the board, including ethics requirements.

That I understand the associate license does not give me the authority to engage in the independent practice of counseling.

That I understand the associate license is only valid while I practice under supervision.

That I notify the board if this supervisory arrangement is terminated.

That I understand any additional supervisors and settings must be approved by the board in advance.

_____ _____/_____/_____

Signature of Applicant Date

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I, as the board approved supervisor of the above named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

That all supervised experience will be completed in accordance with the Law and Regulations related to supervised experience and all subsequent board rules.

That I will provide supervision to the above named applicant at least one hour during each week of documented experience.

That I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.

That I understand that the supervisee cannot engage in the independent practice of counseling until he or she obtains a professional clinical counselor license.

That I understand the supervisory arrangement is only valid while my license remains current.

That I will notify the board if the supervisory arrangement is terminated.

_____ _____/_____/_____

Signature of Supervisor Date

APPLICANT AND SUPERVISOR SHOULD KEEP A COPY OF THIS FORM FOR RECORDS